Chapter XV

MBC'S DIVERSION PROGRAM

A. Overview of Function and Updated Data

This chapter addresses the Medical Board's Diversion Program, which "diverts" substance-abusing physicians out of the enforcement program described in the preceding fourteen chapters and into a program that is intended to monitor them while they attempt to recover from the disease of addiction.[281] The Diversion Program designs a contract with required terms and conditions of participation for a five-year monitoring period, including random bodily fluids testing, required group meeting attendance, required worksite monitoring, and often substance abuse treatment and/or psychotherapy. During participation in the Program, physicians generally retain their full and unrestricted license to practice medicine, and many of them are in fact permitted to practice medicine subject to the terms and conditions of their contracts. Many of them participate in absolute confidentiality — their participation in the Diversion Program is concealed from the Board's enforcement program, their patients, and the public. Those who comply with the terms and conditions of their Diversion Program contract may be "successfully terminated" from the Program after three years of continuous sobriety. Those who violate the terms and conditions of their Diversion Program contract may be "unsuccessfully terminated" from the Program and referred to the enforcement program for the commencement of disciplinary action.

It is important to understand that the Diversion Program is a *monitoring* program, not a treatment program. It does not provide substance abuse treatment; its staff is not authorized or trained to do so. Instead, it evaluates the needs of its participants; provides a rehabilitative plan that directs them to treatment — including inpatient detoxification, medical and psychiatric evaluation, and psychotherapy, as appropriate; monitors their compliance with the terms and conditions of their contract with the Program through a variety of mechanisms (including random drug testing, required

[281] The enabling act of the Diversion Program also refers to physicians with "impairment due to . . . mental illness or physical illness." Bus. & Prof. Code § 2340. However, the Diversion Program has historically and primarily been structured to monitor substance-abusing physicians (or physicians who are "dually diagnosed" with both chemical dependency and mental illness). Despite the inclusion of the terms "mental illness and physical illness" in its enabling act, the Diversion Program was not authorized to "divert" singly-diagnosed mentally ill physicians until January 1, 2003, when an amendment included in SB 1950 (Figueroa) became effective. Thus, for most of its history, the Diversion Program has been structured primarily to monitor chemically dependent physicians, and this chapter focuses on that function.

attendance at group meetings facilitated by Program contractors, and required quarterly reporting by worksite monitors and treating psychotherapists); and is authorized to terminate them from the Program (and refer them to the enforcement program) if they do not comply.

In researching the *Initial Report*, the Monitor studied the Diversion Program's statutes, regulations, and procedure manuals; reviewed prior audits, evaluations, and annual reports of the Program; and extensively interviewed the staff of the Program. The Monitor also examined the files (both paper and electronic) of 60 Diversion Program participants — almost one-quarter of the Program's population — to determine whether the Program is functioning in compliance with its statutes, regulations, and the policies and procedures set forth in its internal manuals.[282] The *Initial Report* provided an in-depth discussion of the Diversion Program's purpose, structure, personnel, participants, and problems.[283] For the convenience of the first-time reader, some of that information is repeated here.

■ ***Statutory purpose***. Business and Professions Code section 2340 *et seq*. — enacted in 1980 — created MBC's Diversion Program and expressly charged MBC's Division of Medical Quality with its oversight and administration.[284] In the enabling legislation, the Legislature stated its intent "that the Medical Board of California seek ways and means to identify and rehabilitate physicians and surgeons with impairment due to abuse of dangerous drugs or alcohol, or due to mental illness or physical illness, affecting competency so that physicians and surgeons so afflicted may be treated and returned to the practice of medicine in a manner which will not endanger the public health and safety."[285] This language thus requires the Board to "identify and rehabilitate" impaired physicians and "return" them to the practice of medicine, but only if this can be done "in a manner which will not endanger the public health and safety." As one of MBC's regulatory programs, the Diversion Program is subject to Business and Professions Code sections 2229 and 2001.1, both of which declare that protection of the public is the highest priority for the Medical Board of California. Both statutes specify that whenever public protection is inconsistent with other interests sought to be promoted, public protection is paramount.

■ ***Program structure, staffing, funding, and participation***. MBC's Diversion Program is one of the few state-sanctioned impaired physician programs to be run from within a state medical

---

[282] *See Initial Report*, *supra* note 13, at 236–38 for a complete description of the Monitor's methodology in evaluating the Diversion Program. Prior to releasing the *Initial Report*, the Monitor team reviewed its findings and conclusions on each of the 60 case files with the outgoing Diversion Program administrator (who resigned in August 2004); the program administrator concurred each of the Monitor's findings concerning individual participants.

[283] *Id*. at 238–54.

[284] Bus. & Prof. Code § 2346.

[285] *Id*. § 2340.

licensing board by employees of that board. As noted in the *Initial Report*, most other state medical boards and California occupational licensing agencies with diversion programs contract out all functions of their impairment programs to the private sector. MBC's Diversion Program contracts out some components of its program, including its drug testing, laboratory, and group meeting components. But the critical case management component and all aspects of the Diversion Program's management and administration are performed by employees of the Medical Board — and have been since the Program's inception in 1981.

At the time of the *Initial Report*, the Program was staffed by a program administrator based in Sacramento; five "case managers" (CMs) scattered throughout the state and working out of home offices, each responsible for overseeing a caseload of participants in their region and ensuring that they comply with the terms and conditions of their contracts; and four support staff based in Sacramento, including a Collection System Manager (CSM) with responsibility for overseeing the Program's urine collection and testing system — the Program's major objective measure of compliance with Diversion contracts. These Board employees are supplemented by thirteen "group facilitators" (GFs) based throughout the state; GFs facilitate biweekly group meetings of Diversion Program participants in their localities. The Program is also assisted by approximately 30 local businesses throughout the state that serve as urine specimen collectors for the Diversion Program.

As described briefly in Chapter V, the Diversion Program maintains the Diversion Tracking System (DTS), its own separate database of information on its participants that is unavailable to Board management or the enforcement program. DTS contains a file on each participant that is supposed to include all personal and professional information on the participant, the terms and conditions of his/her Diversion Program contract (including restrictions on medical practice), and the details of his/her participation in the Diversion Program, including results of all bodily fluids testing (which are downloaded directly into DTS from the laboratory that tests participants' urine samples), absences from required group meetings, and dates of worksite monitor and treating therapist reports.

As of June 30, 2005, 232 physicians were admitted to and participating in the Diversion Program.[286] In fiscal year 2004–05, the Diversion Program cost almost $1.2 million.[287] That cost was subsidized entirely through license fees paid by all California physicians. Participants in MBC's Diversion Program pay nothing toward the overhead costs of the Program. They are required to pay

[286] Medical Board of California, *2004–05 Annual Report* (Oct. 1, 2005) at iv. In addition to its 232 active participants, the Program was also monitoring 28 prospective participants who had signed an "interim agreement" (see below) but had not yet seen a DEC or signed a formal Diversion Program Agreement, and 17 California physicians participating in other-state diversion programs.

[287] *Id*. at ii.

the costs of their own drug testing (approximately $220 per month during the first two years[288]) and group meetings (as of July 2005, $331 per month for two meetings per week[289]), for a total of $551 per month. Additionally, if they are required to undergo substance abuse treatment as a condition of Diversion Program participation, they must pay for that treatment.[290]

■ ***Overview of participation in the Diversion Program***. A physician makes contact with the Diversion Program in one of three ways: (1) he may telephone the Diversion Program at its Sacramento headquarters office seeking information and/or admission into the Program (a so-called "self-referral"); (2) impaired physicians are sometimes detected through complaints or reports made to the enforcement program, and enforcement permits the physician to enter Diversion under a "statement of understanding" (SOU)[291] (these physicians are called "diverted" or "Board-referred" participants); or (3) the Board may order a physician to participate in Diversion as a term of probation in a public disciplinary order ("Board-ordered participants").

Regardless of why the physician is entering the Program, a Program analyst conducts a telephone interview to record basic information about the physician's situation. The analyst checks the enforcement program's CAS computer system to determine whether any complaints are pending against the physician; if not,[292] the analyst relays the information on the prospective participant to the CM with responsibility for covering the geographical area of the state in which the physician lives. Within the next four days, the CM telephones the physician, assesses the situation, and schedules an in-person "intake interview" which should occur within seven days of the physician's

[288] Participants currently pay $20 to the collector for each observed collection, and $35 for laboratory testing of the sample, for a total of $55 per test. During the first two years of participation, participants are tested at least four times per month; thus, participants pay approximately $220 per month for drug testing during the first two years.

[289] At its July 2005 meeting, the Diversion Committee and DMQ approved an increase in group facilitator fees, from $322 per month for two meetings per week (or $225 per month for one meeting per week) to $331 per month for two meetings per week (or $231 per month for one meeting per week).

[290] According to Program staff, inpatient substance abuse treatment ranges from $8,000–$20,000, and is not always covered by insurance.

[291] *See* Bus. & Prof. Code § 2350(b).

[292] If there is a complaint pending against a physician who seeks admission into the Diversion Program, the Program asks the deputy chief of enforcement to "divert" the physician into Diversion. If the complaint is based primarily on "the self-administration of drugs or alcohol under Section 2239, or the illegal possession, prescription, or nonviolent procurement of drugs for self-administration, and does not involve actual harm to the public or [the physician's] patients," the deputy chief "shall refer" the physician to Diversion for an evaluation of eligibility. However, before making the referral, enforcement may require the physician to sign a "statement of understanding" (SOU) in which the physician agrees that "violations of this chapter or other statutes that would otherwise be the basis for discipline may nevertheless be prosecuted should the physician . . . be terminated from the program for failure to comply with program requirements." Bus. & Prof. Code § 2350(b).

initial contact with the Program.[293] At the intake interview, the physician must sign an "interim agreement" with the Program.[294] At this point, the CM is required to do three things: (1) arrange for a comprehensive multidisciplinary physical and mental evaluation of the prospective participant by a physician who specializes in addiction medicine and is competent to recommend the type of treatment and monitoring needed by the prospective participant[295]; (2) refer the physician to a local GF who conducts weekly group therapy meetings attended by other impaired physicians who are participating in the Diversion Program, so that the physician may begin to attend meetings immediately pending his formal admission into the Program; and (3) arrange for random urine testing of the physician commencing immediately.

Once the physician's comprehensive evaluation has been completed, the results and recommendations are forwarded to the CM, who then refers the physician's file to a local Diversion Evaluation Committee (DEC) and schedules the physician for an in-person appointment with the DEC. The Diversion Program maintains five DECs throughout the state; by statute,[296] each DEC consists of five individuals (three physicians and two non-physicians) who have expertise in substance abuse detection and treatment. DEC members are private parties appointed by DMQ.[297] DECs meet quarterly and in private.[298] The DEC reviews the file, meets with the physician, and makes a recommendation to the program administrator whether the physician should be accepted into the Program, whether the physician should be permitted to continue practicing medicine, and the terms and conditions of the physician's Diversion Program contract (including proposed

[293] These timeframe goals are not stated in any statute, regulation, or procedure manual. They are set forth in the Diversion Program's "Quarterly Quality Review" reports that are reviewed by the Diversion Committee at its quarterly meetings.

[294] In the interim agreement, the physician acknowledges that he is applying for admission into the Diversion Program, recognizes that he may have a substance abuse disorder, and agrees to restrict or cease practice if so instructed by the Diversion Program; enter a treatment program if so instructed by the Diversion Program; undergo a minimum of four observed urine tests per month; attend facilitated group meetings with other Diversion Program participants; attend additional group meetings of Alcoholics Anonymous or Narcotics Anonymous, as instructed by the Diversion Program; abstain from the use of alcohol and drugs except those that have been prescribed by another physician and approved by the Diversion Program; refrain from self-prescribing any medications that require a prescription; and immediately report to the Program any relapse or use of alcohol or unauthorized drugs.

[295] Business and Profession Code section 2350(h) requires DMQ to "establish criteria for the selection of evaluating physicians and surgeons or psychologists who shall examine physicians and surgeons requesting diversion . . . ." In 1981, DMQ adopted the following regulation: "A physician selected by the program manager or his/her designee to conduct medical and psychiatric evaluations of an applicant shall be a licensed physician who is competent in his/her field of specialty." 16 CAL. CODE REGS. § 1357.3.

[296] Bus. & Prof. Code § 2342.

[297] *Id*.

[298] *Id*. § 2353.

treatment requirements). The DEC acts in an advisory role to the program administrator.[299] The program administrator prepares a formal Diversion Program contract, and — if the physician signs it — he is formally accepted into the Program.

The time period from the initial contact by the physician with the Program to the DEC meeting and signature on the formal contract generally exceeds three months. In the meantime, the participant is expected to attend two group meetings per week and is subject to at least four random urine tests per month during the first 24 months of participation.[300] If the participant is permitted to practice medicine while participating in the Diversion Program, he must secure a "worksite monitor" who must file quarterly written reports on the participant.[301] In addition, if the participant has hospital privileges, the participant must also secure a "hospital monitor" and notify the well-being committee at each hospital where the participant has privileges. The hospital monitor must also file quarterly written reports on the participant.[302] If the Program requires a participant to undergo psychotherapy, the treating therapist is also required to file quarterly written reports on the participant's progress.[303] The CM is responsible for ensuring that all of these quarterly reports are received, recorded, and forwarded to headquarters for placement in the participant's file.[304]

Assuming no relapses or other noncompliance, the Program's monitoring continues for at least five years.[305] Participants are expected to file semi-annual reports assessing their own progress

---

[299] *Id*. § 2344.

[300] The rules governing the frequency of random urine testing and group meeting attendance do not appear in any statute, regulation, or even the *Diversion Program Manual*. The Program's policy regarding the frequency of random urine testing is contained in a June 30, 2000 memo from the program administrator, which was then clarified in a March 26, 2001 memo from the program administrator. These memos are contained in an undated supplemental compilation of Diversion Program policies prepared for the Monitor entitled *Diversion Program Policy, Guidelines, and Procedures*. The rule concerning frequency of required group meeting attendance appears nowhere — not in any statute, regulation, or procedure manual. The closest the Program comes to defining its expectations regarding required group meeting attendance is Appendix D to its *Diversion Program Manual*, which contains a compilation of materials given to new participants. Appendix D states: "During the first eighteen months of participation in the Diversion Program, most participants are expected to attend two Diversion Group meetings a week. At the end of this period, the participant may request a reduction in meeting attendance from two to one a week. Your request should also be discussed with your facilitator and case manager."

[301] Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at 7.

[302] *Id*. at 7–8.

[303] *Id*. at 8.

[304] *Id*., Ch. 2 at 8.

[305] Due to relapses, however, it takes most participants five to seven years to "successfully terminate" from the Program.

toward recovery;[306] these reports are reviewed by the DEC on an annual basis, along with all of the other documentation that is required to be gathered by the case manager, including quarterly worksite and hospital monitor reports, treating therapist reports, and the participant's drug testing history.[307] After two years of continuous sobriety, urine testing may be decreased to three times per month; after three years, it may be decreased to twice per month. At that point, required group meeting attendance may be reduced to once per week.[308] After three years of sobriety, compliance with the terms of the contract, and adoption of a "lifestyle to maintain a state of sobriety," a participant may be "successfully terminated " from the Diversion Program.[309] At that point, a physician who entered the Program under an SOU is immune from discipline for the alleged violation that resulted in his referral to Diversion.[310] Most Diversion Program records of "successfully terminated" participants — including treatment records — are destroyed.[311] Thereafter, the Program does not inquire into or track the sobriety or performance of its graduates in any way.

Under Diversion Program policy, the consequences for a relapse depend on the facts of the situation, the level of breach, and the way in which it is detected. If the physician is practicing medicine at the time of the relapse, he is usually directed to cease practice until he can meet with the DEC, and is placed on the DEC's calendar for the next available meeting. Depending on the circumstances, the Program may also direct the physician to enter treatment, increase the frequency of required urine testing or group meeting attendance, or require the participant to undergo psychiatric evaluation and/or psychotherapy. According to the *Diversion Program Manual*, "a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program."[312]

In an average of 13 cases per year for the past five years, the Program has "unsuccessfully terminated" a participant. The consequences of "unsuccessful termination" depend on the type of participant who has unsuccessfully terminated. Participants who are in the Diversion Program under

---

[306] Medical Board of California, *Diversion Program Manual* (undated) at Appendix D ("semi-annual reports").

[307] *Id*., Ch. 4 at 1, 3.

[308] *See supra* note 300.

[309] Bus. & Prof. Code § 2350(g)(1).

[310] *Id*. § 2350(g).

[311] *Id*. § 2355(a). A DMQ regulation specifies a few types of Diversion Program records that must be retained in confidence by the Diversion Program. 16 CAL. CODE REGS. § 1357.9.

[312] Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at 4; *see also* Medical Board of California, *Diversion Program Policy, Guidelines, and Procedures* (undated) ("Guidelines for Maximum Relapses While in the Diversion Program") ("a participant in the Diversion Program will be considered for termination when the participant has more than three relapses while in the Diversion Program").

an SOU or as a condition of Board-ordered probation are referred to enforcement, which can then file an accusation for the alleged violation that resulted in the referral to Diversion,[313] or a petition to revoke probation based on the unsuccessful termination. "Self-referred" participants who are "unsuccessfully terminated" will not be referred to enforcement unless the DEC "determines that he or she presents a threat to the public health or safety."[314] According to the Program Administrator, DECs do not generally make such a finding unless the participant is actively using drugs or alcohol. Thereafter, the Program does not inquire into or track the sobriety or performance of participants it has unsuccessfully terminated in any way.

■ ***Prior audits of the Diversion Program***. Prior to the Monitor's examination of the Diversion Program in 2004, the Program had not been subject to an external audit since 1986. Beginning in the early 1980s, the Auditor General's Office (now called the Bureau of State Audits) conducted a series of audits of MBC's Diversion Program. In its three audits,[315] the Auditor General found that participants in the Program were not drug-tested as often as they should be and were not terminated from the Program even after repeated violations; additionally, no standards existed to guide the functioning of "worksite monitors" who purportedly oversee Program participants when they practice medicine. Overall, the Auditor General found that the Program — due in part to severe understaffing — generally failed to adequately monitor substance-abusing physicians while permitting them to practice medicine, and that the Medical Board had inadequately supervised the Program. Despite repeated findings by the Auditor General and repeated promises by the Board to address the problems identified, the *Initial Report* documented that all of these problems continued to exist over twenty years later.

B. The Monitor's Findings and MBC/Legislative Responses

In the *Initial Report*, the Monitor — as did the Auditor General twenty years ago — identified and documented numerous significant deficiencies in the functioning of the Diversion Program.[316] These weaknesses — which range from the philosophical to the structural to the operational — are summarized below. The Monitor then made ten recommendations to MBC regarding the Diversion Program — not all of which could possibly have been implemented in the

---

[313] Bus. & Prof. Code § 2350(e).

[314] *Id*. § 2350(j)(3).

[315] Auditor General of California, *Review of the Board of Medical Quality Assurance* (No. P-035) (August 1982); Auditor General of California, *The State's Diversion Programs Do Not Adequately Protect the Public from Health Professionals Who Suffer from Alcoholism or Drug Abuse* (No. P-425) (January 1985); Auditor General of California, *The Board of Medical Quality Assurance Has Made Progress in Improving Its Diversion Program; Some Problems Remain* (No. P-576) (June 1986).

[316] *Initial Report*, *supra* note 13, at 254–85.

year since the *Initial Report* was issued. As described below, the Medical Board and the Diversion Program have begun to implement those Monitor recommendations that can be achieved with limited staff and resources. Further, MBC has created a new Diversion Committee and charged it with considering and resolving significant policy issues that have long plagued the Program and that could not realistically be addressed in the year since November 1, 2004; those issues — originally identified in the *Initial Report* — are recapped in Chapter XV.C. below. And finally, in SB 231 (Figueroa), the Legislature has given the Committee and the Board a last chance to fully address and resolve the problems that have been repeatedly identified by the Auditor General and now the Monitor. As described in Chapter IV above, the bill requests the Bureau of State Audits to thoroughly audit the Program by June 30, 2007, and places a July 1, 2008 sunset date on the existence of the Program.

1. The Diversion Program is significantly flawed by the simultaneous confluence of (a) the failure of its most important monitoring mechanisms and an insufficient number of internal quality controls to ensure that those failures are detectable by Program staff so they can be corrected, and (b) such pervasive and long-standing understaffing that Program staff could not correct those failures even if they knew about them.

a. All of the Program's most important monitoring mechanisms are failing, and there are an insufficient number of internal quality controls to detect those failures. The primary purpose — and promise — of the Diversion Program is adequate monitoring of impaired physicians while they are impaired, recovering, and retain their full and unrestricted license to practice medicine. The Program purports to monitor impaired physicians through a variety of mechanisms, the most important of which are: (1) random urine screening requirements; (2) case manager attendance at required group meetings; (3) required worksite monitoring; and (4) regular reporting to the Program by psychotherapists who are treating participants.

In the *Initial Report*, the Monitor found — as did the Auditor General in its three reports during the 1980s — that all of these monitoring mechanisms were failing the Program and the public, and that the Program lacked internal quality controls that would otherwise enable staff to detect these failures. As a result, Program staff and oversight authorities were unaware of the deficiencies that existed in the Program and falsely assumed that the Program was effectively monitoring participants when it was not. Following is a brief summary of the Monitor's *Initial Report* findings about each of the Diversion Program's monitoring mechanisms.

(1) The Program's urine collection system is fundamentally flawed. The Diversion Program uses random urine collections as a primary means of monitoring participants' sobriety and detecting relapses. Available data suggest that more than 70% of relapses are detected directly, or indirectly, from these tests. Thus, the Diversion Program's urine collection system is the major

objective measure of participant compliance with the terms of the contract and with the Program's requirements.

As described above, the Sacramento-based Collection System Manager (CSM) is supposed to maintain a "master collection schedule," generate random dates on which Program participants must be tested by local collectors, forward the testing schedule to local collectors and to regional case managers (CMs), and generally provide "oversight and coordination for the collection system process" and "the integrity of the collection system."[317] The CMs are required to monitor a caseload of participants in their region and ensure that all participants comply with all terms and conditions of their Diversion Program contracts — including required urine testing. Both of these "gatekeepers" are in a position to monitor participant compliance with the Program's urine collection requirements.

However, the Monitor found that, because of other Program responsibilities and a shortage of staff, the CSM was only able to devote two hours per month to her CSM duties; all she was able to do within that timeframe was generate the random schedule and send it to collectors. The CMs were burdened by excessive caseloads and could barely respond to positive tests much less track whether each participant was being tested as often as required and on the random dates generated by the CSM. The local collectors were essentially unsupervised and were free to adjust the random schedule to suit their convenience. They often unilaterally shifted collections to dates that could be anticipated by the participants,[318] or skipped scheduled tests altogether and failed to make them up. These failures went undetected by Program staff. The "gatekeepers" simply assumed that collections were completed as required and scheduled, that test results were negative unless they received a positive finding from the laboratory, and that all test results were being correctly downloaded and appended to each participant's record in the DTS. All of these assumptions were frequently erroneous. The Monitor found that there were insufficient positive controls on the collection system to provide assurance of six major components of the Program's urine collection system:

a. All active participants are included in the master collection schedule maintained by the CSM.
b. Each participant is scheduled for the required number of tests, per the Diversion Program's "frequency of testing" policy described above.
c. Collections are actually completed on the random dates assigned by the CSM.

---

[317] Medical Board of California, *Diversion Program Manual* (undated), Ch. 5 at 3.

[318] In this regard, the Monitor found that collectors disproportionately shifted collections from weekend days (Friday, Saturday, and Sunday) to weekdays, particularly Tuesday and Thursday. The reduced frequency of testing on weekends and increased frequency of testing on Tuesdays and Thursdays potentially enables participants to "game" the system by anticipating when they are least likely to be tested. *Initial Report*, *supra* note 13, at 260.

d. The same number of collections is completed as is scheduled for each participant.
e. Collected specimens are received at and processed by the laboratory.
f. Test results are correctly downloaded and appended to each participant's record in the DTS.

Due to the absence of sufficient positive controls over the scheduling and collection process, the Monitor — like the Auditor General in the 1980s[319] — found that many Diversion Program participants were tested less frequently than required, or not tested at all, for an extended period of time without anybody ever detecting that there was a problem. In 60% of the case files reviewed by the Monitor, testing did not occur on the random dates generated by the CSM; when it occurred, it occurred with frequency on dates that could be anticipated by the participant. In many cases, test results (including positive test results that indicate relapse) were not promptly communicated from the lab to the Program. When test results were received, they were sometimes appended to the wrong participant's record in the DTS, or not appended to any record in the DTS, without anybody ever detecting that there was a problem. The Monitor found numerous errors, gaps, and inconsistencies in the Program's recordkeeping on its participants — recordkeeping that must be available, correct, and reliable in the event of a relapse.[320]

(2) It is unclear whether the case managers are attending group meetings as required by Diversion Program policy. The Program's case managers represent another "monitoring" mechanism of the Diversion Program.[321] The *Diversion Program Manual* requires case managers to attend each group meeting in his/her geographic area once a month in order to observe both the group facilitators and the participants.[322] Case managers are required to report their group meeting attendance in monthly reports to the program administrator.[323] However, the Monitor — like the

[319] The Auditor General's 1985 and 1986 reports found that the Diversion Program does not test its participants as frequently as Program policy requires. *See Initial Report*, *supra* note 13, at notes 444–45.

[320] *See Initial Report*, *supra* note 13, at 258–65 for a detailed description of the defects in the Diversion Program's urine collection system.

[321] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[t]he role of the case managers is to ensure that the participants who are assigned to them comply with the provisions of their Diversion Agreements and are solidly in the recovery process. The Case Manager has direct contact with each participant every 4–8 weeks").

[322] Medical Board of California, *Diversion Program Manual* (undated) at Ch. 2, p. 5 ("CMs attend the facilitators' group meetings once a month to observe the facilitators and participants").

[323] Medical Board of California, *Diversion Program Manual* (undated) at Ch. 1, p. 12.

Auditor General in the 1980s[324] — found that few case managers filed monthly reports as required, so there was no documentation as to whether they had attended group meetings as required by Program policy.

(3) Worksite monitoring and reporting is deficient. The Program assures the public that if impaired physicians are permitted to practice medicine, they are "monitored" by non-impaired physicians.[325] However, since its inception, the Program has set forth no workable definition of the duties, qualifications, or expectations of a "worksite monitor."[326] Although some Diversion Program materials convey the idea that participants are "supervised" while practicing medicine, that is not the case. No statute, regulation, or procedure manual contains a definition of or standards for a "worksite monitor." The *Diversion Program Manual* contains no requirements that the worksite monitor actually be onsite at the same time as the participant, supervise the participant in any way, or even meet with or talk to the participant. The *Manual* sets forth no qualifications or criteria for someone functioning as a "worksite monitor," nor does it even require the monitor to be a physician.

Further, the Monitor found that people functioning as worksite monitors were not consistently filing quarterly reports as required by the Program. Yet in many cases reviewed by the Monitor, DECs recommended that participants be allowed to increase their practice hours or — in one case — resume practice on a full-time basis notwithstanding continuing deficiencies related to the submission of quarterly worksite monitoring reports.

(4) Treating psychotherapist reporting is deficient. The Diversion Program assures the public that impaired physicians are monitored by treating psychotherapists who are required to file quarterly written reports with the Program.[327] However, the Monitor found that this monitoring

---

[324] The Auditor General's 1982, 1985, and 1986 reports identified the problem of inconsistent or inadequate contact by case managers with participants. *See Initial Report*, *supra* note 13, at notes 449–51. The Auditor General's 1985 and 1986 reports documented the problem of inadequate reporting by case managers and inadequate supervision of case managers by the program administrator. *See Initial Report*, *supra* note 13, at notes 452–53.

[325] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including "worksite monitor(s)" and "hospital monitor(s)"] is used in order to ensure patient safety and provide strong support for the physician's recovery").

[326] The Diversion Program's failure to adequately define the duties, qualifications, and functions of worksite monitors and the failure of worksite monitors to submit quarterly reports were identified by the Auditor General in 1982, 1985, and 1986. *See Initial Report*, *supra* note 13, at notes 455–57.

[327] Medical Board of California, *Physician Diversion Program* (March 2000) at 2 ("[p]articipants are closely monitored while in the Diversion Program. A wide variety of monitoring components [including "ongoing psychotherapy" and "progress reports: therapists, monitors, treating physicians"] is used in order to ensure patient safety and provide strong support for the physician's recovery"). *See also* Medical Board of California, *Diversion Program Manual* (undated), Ch. 1 at p. 8 (treating psychotherapist quarterly report requirement).

requirement was not being satisfied. Neither the case managers, the program administrator, nor the DECs (which annually review all Program participants) were ensuring that quarterly treating psychotherapist reports were filed.

b. The Program is so understaffed that staff could not correct the failures in its monitoring mechanisms even if they knew about them.

In the *Initial Report*, the Monitor found significant understaffing of the Diversion Program at all levels: program management, case management, and analytical/clerical support staff. The program administrator was charged with (1) supervising the case managers and support staff; (2) making Program policy decisions; and (3) engaging in overall program oversight, including fact-based decisionmaking concerning participants — a burdensome combination of duties that one person cannot competently handle alone. In 2002, case manager caseloads soared to over 80 cases for three of the five CMs, leading to inadequate monitoring of participants and failure to ensure compliance with all Program requirements. Even the Program recognized its staffing limitations and began to turn away prospective participants.[328] The employee in the critical CSM position — implied to be a full-time position devoted to ensuring the integrity of the collection system in the *Diversion Program Manual* — was so overloaded with unrelated responsibilities that she was incapable of devoting more than two hours per month to urine collection system oversight. The four Sacramento-based support staff could not possibly keep up with their Program-related work responsibilities (including the calendaring and staffing of all DEC meetings all over the state) plus the work necessary to accommodate the needs of the Diversion Committee, the Liaison Committee, and the Division of Medical Quality.

In Recommendation #58 of the *Initial Report*, the Monitor found that — if the Medical Board chooses to continue administering the Diversion Program — DMQ must spearhead a comprehensive overhaul of the Program to correct longstanding deficiencies that limit the Program's effectiveness. This overhaul must include an influx of additional staff if the Program is to adequately monitor its participants. However, the Monitor emphasized that the mere addition of staff alone will not solve the Diversion Program's problems. In addition, the Program must install and staff sufficient and significant internal quality controls to ensure that all of its various monitoring mechanisms are functioning to detect relapse or pre-relapse behavior. According to the Monitor, "[i]t is abundantly clear that the Program has functioned without adequate internal controls for 24 years. These controls

[328] Beginning in March 2002, case manager caseloads in certain parts of the state were deemed so excessive that Program management curtailed entry into the Program by participants who would have been served by those case managers, and simultaneously lessened the participant monitoring expected of those case managers. Today, in 2005, at least one CM still has an excessive caseload.

must be designed, installed, and adequately staffed."[329] Finally, any restructuring of the Diversion Program must include the resolution of significant and longstanding policy issues by the Diversion Committee and DMQ; those policy issues are detailed in Chapter XV.C. below.

To address fundamental flaws in the Program's monitoring mechanisms, MBC Executive Director Dave Thornton — who personally stepped in and served as Acting Diversion Program Administrator from August 2004 through February 2005 — announced in January 2005 his intent to "deconstruct and reconstruct" the Diversion Program, and has taken several initial steps toward this goal. Since February 2005, there has been almost complete turnover in the staff of the Diversion Program — almost all Program staff are new, have no commitment to or stake in the Program's prior policies and procedures, and appear to be committed to the purpose of the Program (protection of the public while assisting impaired physicians to recover from addiction). The following improvements have occurred since the release of the *Initial Report*:

■ ***Diversion Program staffing***. Effective February 17, 2005, MBC hired a new Diversion Program Administrator who has significant experience in both enforcement and in impairment programs. The new administrator has been instrumental in addressing several of the operational deficiencies identified by the Monitor. On February 8, 2005, MBC added a new management position to the Diversion Program — a supervisor for the case managers. Although this individual was required to carry a CM caseload until June 1, 2005, since then she has been active in providing critically needed supervision of the CMs. She ensures that CMs are filing required monthly reports on their activities, and that those reports contain documentation of their attendance at group meetings — as required by Program policy. She ensures that CMs acquire, and forward to Sacramento headquarters, required quarterly worksite monitor and treating psychotherapist reports. Under the direction of the new program administrator and CM supervisor, the case managers have been moved out of their former home offices and now work from Medical Board district offices. They access the DTS from MBC computers and have office space (including locking cabinets for confidential Diversion Program files) in Medical Board facilities. This change has led some of the prior CMs to resign or retire — paving the way for the new Program management to hire new case managers who have no familiarity with the way the Program previously functioned.

Significantly, on March 1, 2005, the Program formally expanded its existing Collection System Manager position to a full-time position devoted almost entirely to overseeing the operations and integrity of the Program's urine collection system; additionally, another Program analyst has been cross-trained to handle CSM duties when the CSM is on vacation or otherwise out of the office. The new CSM is in the process of completely rebuilding the Program's urine collection system from the ground up (see below for details).

---

[329] *Initial Report*, *supra* note 13, at 273.

Finally, MBC has submitted a budget change proposal (BCP) for additional Diversion Program case managers and the conversion of a seasonal clerical position to a permanent position. The additional CM positions are of particular importance; if approved, average CM caseloads will decrease from over 50 cases to approximately 40 cases each — and should enable CMs to adequately monitor participants and greatly improve the public protection afforded by the Diversion Program. Funding for these positions was included in the Board's calculation of the fee increase which was included in SB 231 (Figueroa) — now passed by the Legislature and signed by the Governor. The Monitor urges all applicable control agencies to approve the creation of these new positions for the Diversion Program.

■ ***Improvements to the Program's urine testing system***. As noted above, the Medical Board has finally devoted a full-time analyst position to the Diversion Program's critical CSM function. The new CSM has contacted all Program CMs, GFs, and urine collectors and reinforced the Program's expectations of each regarding performance and regular and complete reporting of that performance. She has created a monthly reporting form for local urine collectors which requires them to document that they have administered tests on the random date scheduled, and instituted a policy requiring advance notification of and written justification for the adjustment of any of those test dates. She has established regular contacts with the Program's CMs to ensure that they provide her with updated information regarding the identities of new participants who should be added to the master collection schedule, participants who have gone into treatment, and participants who are on vacation or are otherwise unavailable for Program urine testing — so the master collection schedule can be adjusted and the dates for testing can be randomly established by the CSM (and not by CMs and collectors). Upon her recommendation, the Program has terminated several collectors who would not adhere to the random schedule and other Program requirements, and brought in others who are willing to do the job expected of them.

Unhappy with the error-riddled and obsolete Diversion Tracking System, MBC management in late 2004 commissioned the Board's Information Systems Branch (ISB) to create a new DTS to electronically track data (including all results of urine tests) on all Diversion Program participants. As described in Chapter V, ISB was able to create a new system that was up and running as of July 1, 2005. The DTS is now a Web-based real-time system that is accessible to Program case managers at MBC district offices. Although the new DTS is operational, it is still a work in progress as new features are being added or enhanced. ISB has created a program whereby urine test results forwarded by the lab are automatically downloaded to the DTS and appended to the tested participant's DTS file (which is being spot-checked for accuracy by the CSM). As of September 1, 2005, ISB installed a new "random date generator" (RDG) that produces monthly schedules for random drug testing of Program participants. Staff plans to adhere strictly to the random dates generated by the RDG, and not to manually tinker with dates selected (except to add additional tests or "elite" tests so that the Program's frequency of testing policy becomes a floor and not a ceiling).

Finally, ISB is in the process of creating a new "exception report" that will compare the randomly scheduled dates to the dates of actual testing, and identify tests conducted on dates other than randomly-scheduled dates.

Collectively, MBC's recent changes to the Diversion Program's urine collection system have addressed the six missing assurances identified by the Monitor as follows:

a. *All active participants are included in the master collection schedule*: Because of previously inaccurate recordkeeping and the errors in the DTS, the new CSM was required to manually compile an accurate list of active Program participants who are subject to urine testing. She then reconciled that list with the master collection schedule to ensure that the name of every active participant in the Diversion Program is on the schedule and is programmed for the correct number of tests per month pursuant to Program policy. To keep the schedule updated, the CSM has frequent communications with the Program's CMs and GFs to ensure that all active participants are listed on the master schedule — that is, new participants are added and participants in treatment are temporarily deleted (but are added back immediately upon their release from treatment). The goal is to ensure that the CSM establishes random testing dates — not the CMs or the local collectors.

b. *Each participant is scheduled for the required number of tests, per the Diversion Program "frequency of testing" policy described above*: The new CSM has manually recalculated applicable testing requirements for each active participant, and is manually verifying that all participants are being given the minimum number of tests per month as required by Program policy. Program staff is also studying and reevaluating the Program's "frequency of testing policy" (a minimum of four tests per month during the first two years of participation; then — assuming no relapse — three tests per month during the third year and two times per month during subsequent years). According to Program staff, this test rate "drop-off" at these intervals is no longer automatic, but is within the discretion of the Program. Staff is also examining "frequency of testing policies" in other states.

c. *Collections are actually completed on the random dates assigned by the CSM*: The CSM is requiring monthly reports from collectors that document and verify that tests have been administered on the random dates selected by the computer. Collectors must submit advance notice of any change in those dates to the CSM, and must provide written justification for the change in their monthly reports.

d. *The same number of collections is completed as is scheduled for each participant*: Currently, this factor is being manually checked by the full-time CSM; however, she will soon be assisted by the new "exception report" function being developed by ISB.

e. *Collected specimens are received at and processed by the laboratory*: This factor is being checked by the full-time CSM.

f. *Test results are correctly downloaded and appended to each participant's record in the DTS*: Currently, the CSM performs spot checks to ensure accuracy in the DTS receipt and recording of test results. At the end of every month, the CSM has been manually verifying the accuracy of lab test reporting displayed on DTS (ensuring that the number of required tests has been administered, and that all tests have been administered on the random dates selected by the computer). In the near future, manual checking will be unnecessary because of the new"exception report" function being developed by ISB.

■ ***Case manager attendance at group meetings***. The new case manager supervisor now requires and reviews monthly reports filed by case managers that document their compliance with the Program's policy of CM attendance at each group meeting in their region at least once monthly. Most CMs are able to comply with that requirement now. If a CM is burdened by an excessive caseload and is unable to attend group meetings as required, the program administrator and/or case manager supervisor attempt to fill in for them at group meetings. As noted above, MBC has submitted a BCP for additional CMs, which will assist in lowering all CM caseloads and enable CMs to fulfill this monitoring duty.

■ ***Worksite monitoring standards and reporting***. Under the supervision of the new case manager supervisor, CMs are now beginning to address issues related to the timely filing of quarterly worksite monitor reports. Program staff is working with ISB to develop a program whereby a list of participants who are not in compliance with the worksite monitor requirement is generated.

Although worksite monitor reporting has improved, the Diversion Committee has not yet established meaningful standards for actual worksite monitoring — that is, the duties, responsibilities, and qualifications for worksite monitors. This issue is listed in Chapter XV.C. below. The Program's CMs are currently responsible for ensuring that each participant has secured one or more worksite monitors (as required by Diversion Program policy) who are willing to perform the job and file quarterly reports, and for communicating with worksite monitors. However, the parameters of worksite monitoring must be fleshed out by the Diversion Committee and DMQ. Among those job duties should be a responsibility for monitoring the availability of drugs and narcotics at the workplace, especially small or sole practitioner physicians' offices. Importantly, the

Program's new management has instituted a policy change and will no longer approve a DEC recommendation to increase a participant's work hours (or lower his testing frequency) if the participant is not in compliance with the Program's worksite monitor reporting requirements.

■ ***Treating psychotherapist reporting***. Under the supervision of the new case manager supervisor, CMs are now beginning to address issues related to the timely filing of quarterly treating psychotherapist reports. As noted above, the Program will no longer approve the recommendation of a DEC for increased working hours (or a "drop-off" to lesser testing frequency) for participants who are not in compliance with the Program's treating psychotherapist reporting requirements.

2. The Program suffers from an absence of enforceable rules or standards to which participants and personnel are consistently held.

In the *Initial Report*, the Monitor found that the Diversion Program is plagued by an almost complete lack of enforceable rules, standards, or expectations to which participants or staff are consistently held. The Diversion Program's statutes and regulations are skeletal at best. None of the monitoring mechanism described above are even mentioned in, much less governed by, statute or regulation. All of the monitoring mechanisms and other Program "rules" and "policies" are contained in an unenforceable "procedure manual" that has not been updated since 1998 and is effectively obsolete.

Despite statutory requirements to the contrary, the Program has no meaningful criteria for admission to the Program or termination from the Program. It has no clear standards regarding consequences for or response to relapse. Although the *Diversion Program Manual* contains documents entitled "Response to Relapse" and "Relapse Response Matrix," neither document was ever reviewed and approved by the Diversion Committee or DMQ, both are unenforceable, and neither provide much guidance to DECs or Program staff. The Program's policies have been applied in ways that allow chronic repeat offenders — physicians who have had multiple "bites of the apple" and are simply wasting the time and limited resources of the Diversion Program — to remain in the Program and to remain licensed as physicians.

As far back as 1985, the Auditor General concluded that the Medical Board must "[s]pecify for the program manager of the diversion program the kinds of noncompliance that warrant suspension or termination," and "develop a reporting system for the diversion program that will provide the medical board with enough information to supervise the program properly."[330] Over 20 years later, DMQ has still failed to establish meaningful and enforceable standards for the handling

[330] *See* 1985 Auditor General Report, *supra* note 315, at 22–32.

of relapse by Diversion Program participants and for termination from the Program — apparently preferring to delegate to DECs and the program administrator a "case-by-case" approach. The Monitor appreciates the difficulty of fashioning a "one-size-fits-all" rule regarding relapse, but it seems patently unfair to both physicians and consumers that chronic relapsers who repeatedly and egregiously violate the terms of their Diversion contracts remain in the Program while other physicians genuinely seeking help are denied admission because of resource constraints and the Program's unwillingness to terminate the chronic relapsers.

In Recommendation #58, the Monitor stated that DMQ must adopt meaningful criteria for acceptance, denial, and termination from the Diversion Program, and standards for the Program's response to relapse. In Recommendation #62, the Monitor suggested that DMQ establish enforceable standards and consistent expectations of Diversion Program participants and staff through legislation or the rulemaking process, and oversee a complete revision of the *Diversion Program Manual*.

On its own, staff was not able to address these recommendations unilaterally other than to commence an overhaul of the *Diversion Program Manual* — that project is under way. The redrafted manual must be reviewed by MBC's legal counsel, the Diversion Committee, and DMQ. During 2006, the Diversion Committee and DMQ must address the fundamental policy issues listed in Chapter XV.C. below.

As noted above, SB 231 did not amend substantive law governing the Diversion Program. However, the bill sunsets the whole program effective July 1, 2008, thus requiring the Legislature to pass and the Governor to sign extension legislation in 2007. For inclusion in that extension legislation, the Diversion Committee and DMQ should submit any substantive policies they have developed — for example, meaningful criteria for termination from the Program; and/or a Penal Code section 1000-type mechanism applicable to Board-ordered and Board-referred participants, which may excise repeat offenders from the Program and result in the revocation of their license without further procedure.[331]

3. Contrary to statute, the Division of Medical Quality has never taken "ownership" of or responsibility for the Diversion Program.

State law requires DMQ to administer the Diversion Program and oversee its functioning.[332] However, the Auditor General reports during the 1980s universally found that the Division has failed

[331] *See Initial Report*, *supra* note 13, at 288; *see supra* Chapter XV.C. below.

[332] Bus. & Prof. Code § 2346.

to adequately supervise and oversee the Diversion Program.[333] The 1985 report could not be more clear: "The diversion program of the Board of Medical Quality Assurance does not protect the public while it rehabilitates physicians who suffer from alcoholism or drug abuse. . . . The medical board has allowed these problems to develop because it has not adequately supervised the diversion program."[334]

One of the reasons for DMQ's failure to adequately oversee the Diversion Program lies in MBC's 1982 creation of the "Liaison Committee to the Diversion Program" (LCD) — a committee which has no statutory existence or authority but was formed and funded by the California Medical Association (CMA), the California Society of Addiction Medicine (CSAM), and (recently) the California Psychiatric Association (CPA). As described in the *Initial Report*,[335] the LCD consists of the chairperson of each DEC and representatives from CMA, CSAM, CPA, and MBC. Although the LCD was intended to be an advisory body that could offer clinical expertise on addiction issues to DMQ and MBC staff who administer the Diversion Program, over the years it has been delegated responsibility for or has inserted itself into operational, legal, and other issues that do not require clinical expertise. In the past, staff of the Diversion Program has interpreted Liaison Committee directives and recommendations as orders, and has implemented them without DMQ or Diversion Committee review.[336] More recently, MBC has created a standing Diversion Committee which has attempted to oversee the Program and its functioning, but that Committee has inherited the existence of the Liaison Committee and has not always been willing or able to carve out its own role.

---

[333] *See* 1982 Auditor General Report, *supra* note 315, at 36 ("the board has not established policies governing frequency of contact with participants"), 40 ("the board has not established policies for approving and monitoring supervised, structured environments for Diversion Program participants"), 43 (the board has failed to establish "standards and guidelines for terminating participants"). *See also* 1986 Auditor General Report, supra note 315, at 21 ("[t]he Board of Medical Quality Assurance has improved some elements of its diversion program for physicians; however, further improvement is needed. . . . [T]he board still does not routinely monitor physicians in the diversion program adequately").

[334] *See* 1985 Auditor General Report, *supra* note 315, at 29.

[335] *Initial Report*, *supra* note 13, at 247.

[336] In 1999 documents, the Liaison Committee noted that it had engaged in numerous activities and made many recommendations regarding the functioning of the Diversion Program over the prior five years. Those activities include a report and recommendation on the Program's urine testing program (Oct.16, 1998); a recommendation on elements which should be included in the clinical evaluations of physicians applying for or participating in the Program (Feb. 25, 1998); a report specifying the role and responsibilities of the DEC member who is serving as a case consultant, plus two measures for identifying whether a case consultant is carrying out the intended function (Aug. 21, 1996); and the adoption of a policy in 1994 requiring group facilitators to maintain a current file on each participant. Liaison Committee to the Medical Board's Diversion Program, *Testimony before the Medical Board's Diversion Task Force* (Jan. 20, 1999) (on file at CPIL); *see also* Liaison Committee to the Medical Board's Diversion Program, *Agenda Packet for May 27, 1998 Meeting* (Agenda Item V.F. regarding Facilitator Records) (on file at CPIL). None of these recommendations were ever discussed, reviewed, or ratified by DMQ at any public meeting.

In Recommendation #59, the Monitor urged DMQ to reclaim its authority and jurisdiction over the Diversion Program by abolishing the Liaison Committee as it currently exists. The Monitor noted that the Liaison Committee has evolved into an unwieldy 19-member committee whose members have not been chosen by DMQ, whose purpose is unclear, and whose output is modest and excessively delayed. In the view of the Monitor, DMQ and the Diversion Committee should determine whether there is a need for external clinical expertise and — if so — convert the Liaison Committee into a workable advisory panel that both serves the needs of DMQ (as determined by DMQ) and makes the very best use of the skills, expertise, and time of Liaison Committee members.

In response, MBC President Ronald Wender, M.D., has appointed a new Diversion Committee headed by DMQ member Martin Greenberg, Ph.D. Dr. Greenberg and the Committee are actively reconsidering the purpose and role of the Liaison Committee, and ways in which volunteer addiction professionals can best provide input to the Program on issues that require clinical expertise. This issue will be discussed at the Commmittee's November 2005 meeting and at a special meeting of the Diversion Committee to be scheduled in late 2005 or early 2006.

4. The Diversion Program is isolated from the rest of the Medical Board; its management has not been consolidated into enforcement management or general MBC management.

As described in the *Initial Report* and briefly in Chapter V above, the management of the Diversion Program is not well-integrated into overall MBC management. For many years, the Medical Board — both the Board and its staff — has permitted Diversion to effectively function in a vacuum. Considering the current confidentiality under which the Diversion Program operates, it is not unreasonable that the identities of self-referred Diversion Program participants be concealed from the enforcement program and from MBC management. However, the entire operation of the Diversion Program has been walled off from the rest of MBC management. In the Monitor's view, this separation resulted in the breakdowns in overall Diversion Program functioning and in the key monitoring mechanisms described above — breakdowns that pose a risk not only to the public but also to the physicians participating in the Program, and which were not communicated to MBC management so they might be addressed. In Recommendation #62, the Monitor suggested that MBC more effectively integrate and incorporate Diversion Program management into overall Board and enforcement program management — especially concerning Board-ordered and Board-referred participants who are participating in Diversion in lieu of being disciplined.

MBC has responded to this recommendation positively. As noted above, it has hired a new program administrator who has extensive experience in both enforcement and impairment programs; he has presented training programs to MBC investigators regarding the Diversion Program, and has met with all of MBC's supervising investigators to advise them of changes to the Diversion Program.

Both the new program administrator and the new case manager supervisor have been actively interacting with MBC's enforcement program and its probation monitors with respect to Board-ordered and Board-referred participants. Board-ordered participants are required to sign a release authorizing Diversion to communicate with Probation (and vice versa) concerning their progress or lack thereof. Diversion Program case managers now contact probation monitors any time a Board-ordered participant is ordered to cease practice. According to Diversion Program officials, there is increased dialogue among MBC's diversion, enforcement, and probation programs concerning these participants. Further, and as described above, the new program administrator has moved the Diversion Program's case managers from their home offices into Medical Board district offices. The CMs now function from MBC offices, where they can access the DTS and interact with MBC investigators. Finally, the Diversion Program is actively working to revamp the obsolete *Diversion Program Manual* — a key management function that was ignored for many years.

5. The Program's claim of a "74% success rate" is misleading.

In the *Initial Report*, the Monitor noted that the Diversion Program periodically calculates the total number of admissions into the Program, the total number of "successful completions," and the total number of "unsuccessful terminations." Based on this calculation, the Program advertises a "success rate."[337] This is misleading. The Diversion Program does no postgraduate tracking of its participants — either successful or unsuccessful — in any way, so it has no information on whether those physicians are safely practicing medicine, whether they have relapsed into unmonitored drug/alcohol use, or whether they have died from it. The Program has no idea whether it is successful in rehabilitating physicians over the long term. At the very least, such a "success rate" claim should not be made without fully explaining its meaning.

The Monitor also noted another oft-repeated statement made by former Program staff, former Diversion Committee members, and Liaison Committee members to the effect that "no patient has ever been injured by a physician in the Diversion Program."[338] This is similarly misleading and probably untrue. Injury to patients is not the type of information that participants would ever volunteer or that the Program generally captures or publicizes. The *Initial Report* identifies at least

[337] For example, in its March 2000 brochure, the Program announced that "[f]rom the inception of the Diversion Program in 1980 to March 1, 2000, there have been 981 participants. Six hundred sixty-three (663) of these have completed the program successfully. After factoring out physicians who did not complete for reasons unrelated to their disorders, this results in a 74 percent success rate."

[338] In fact, the Liaison Committee has included this very statement in a September 2005 report accompanying the minutes of its October 6, 2005 meeting. Liaison Committee members have no access to Diversion Program participant files and have no idea what is in them or not in them. While the Diversion Program itself cannot be expected to publicize information on patient harm caused by a participant, the news media has. *See*, *e.g.*, David Washburn and David Hasemyer, *Substance Abuse Program Criticized as Full of Loopholes*, S.D. UNION-TRIB., Mar. 11, 2002.

one case in which a Program participant injured a patient.[339] And, as the Monitor testified to the Joint Legislative Sunset Review Committee in January 2005, the Monitor team's research of participant files revealed at least five additional cases where Diversion Program participants who were permitted to practice medicine were caught using drugs while on duty by their employers. In most of these cases, the participants had stolen or diverted narcotics at their workplace, used while on duty, and tested positive while on duty in a test administered by their employers. Most disturbingly, the statements of these participants to their employers after the detection — which were reported to the Diversion Program not by the participants but by their employers — revealed that they had been using while practicing medicine for a period of months. Yet none of the Diversion Program's monitoring mechanisms detected their relapse. These cases illustrate the severe degree of risk and endangerment to which patients are exposed when the monitoring mechanisms of the Diversion Program fail.

The current management and staff of the Diversion Program have ceased making either claim. Although no concrete plans have been developed, staff is discussing the possibility of arranging for an external long-term study of both "successfully terminated" and "unsuccessfully terminated" Diversion Program participants in an attempt to determine whether the Program is effective in assisting physicians to recover from addiction. Obviously, the Program would need the consent of its participants to pursue such a study. However, such an assessment would provide invaluable information and enable informed decisionmaking to guide future Diversion program structure and operations.

C. Recommendations for the Future

Within a short time period and under severe budget constraints, MBC management has added staff and made other enhancements to the Diversion Program that have significantly improved its operations. Part of the fee increase in SB 231 (Figueroa) is earmarked for additional Program staffing, which is necessary in order to lower caseloads and further improve the Program's monitoring of its participants.

In the *Initial Report*, the Monitor presented some fundamental threshold issues for consideration by MBC. The Monitor suggested in Recommendation #56 that MBC reevaluate whether the "diversion" concept is feasible, possible, and consistent with the Medical Board's "paramount" public protection priority. If the Board concludes that the concept is feasible, the Monitor suggested in Recommendation #57 that MBC then determine whether to house the diversion program within the Medical Board or contract it out to a private entity, as do the vast majority of

[339] *See Initial Report*, *supra* note 13, at 277 (self-referred participant relapsed several times during August and September of 2003 and "overmedicated a patient [and] was observed carrying unnecessary medications on his cart").

other state medical boards and California boards with licensee impairment programs. Neither of these threshold issues were directly addressed by MBC during 2005. However, the Board has created a mechanism — a new Diversion Committee — to consider the other policy issues raised by the Monitor and listed below. SB 231's July 1, 2008 sunset date on the Diversion Program should serve as an incentive for the Committee and DMQ to fully and finally resolve these significant and longstanding policy issues:

1. Whether Diversion Program participation should be an "entitlement" for any and all impaired California physicians, or whether its participation should be capped at a maximum that can meaningfully be monitored by the staff allocated to the Program (Monitor's *Initial Report* Recommendation #60).

2. Whether the Diversion Program should charge participants who are practicing medicine participation fees to cover part of the overhead of the Program — as several other agencies do (Monitor's *Initial Report* Recommendation #60 and discussion at page 241, note 390).

3. Development of meaningful "worksite monitor" and "hospital monitor" standards, criteria, and requirements (*Initial Report* discussion at pages 267–69).

4. Development of meaningful consequences for relapse, including a review of the Relapse Referral Matrix contained in the *Diversion Program Manual*. The matrix should be restated and adopted as policy or regulations to provide consistent guidance to the DECs and Program staff (*Initial Report* Recommendation #58 and discussion at pages 245, 275–77).

5. Consideration of the establishment of consistent criteria for termination from the Diversion Program (for example, "three strikes and you're out") (*Initial Report* Recommendation #62 and discussion at pages 274–80).

6. Consideration of the establishment of a mechanism that not only terminates Diversion Program participation but also revokes the license of Board-ordered and Board-referred "repeated-bite-of-the-apple" participants who have been admitted to the Program, terminated for noncompliance, readmitted to the Program, terminated for noncompliance, etc. (*Initial Report* Recommendation #62 and discussion at pages 277–80).

    a. For example, use of a Penal Code section 1000-type mechanism where a repeat offender is required, upon his second or third admission to the Diversion Program, to sign a stipulated surrender of his license which is then filed while he is participating in Diversion. If he violates his contract, that stipulation is resurrected and not only is he terminated from the Program but his license is revoked without further proceedings.

b. As an alternative, MBC should develop standards for the filing of a petition to revoke probation and revoke the license of a Board-ordered participant after X number of relapses while in the Program. This would take more time and require additional procedures that are avoided in 6(a) above.

7. Review and evaluation of the appropriate role, purpose, and structure of the Liaison Committee to the Diversion Program (*Initial Report* Recommendation #59 and discussion at pages 280–81).

8. Protocols for the Diversion Program's communication with MBC's enforcement and probation programs on participants who are Board-ordered and/or Board-referred. There should be a greater level of communication between Diversion and enforcement on these participants, who are participating in Diversion in lieu of enforcement.

9. The categories of information that should be included in "quarterly quality review" (QQR) reports from Program staff to Diversion Committee members that would enable the Committee to responsibly oversee the functioning of the Program as required by law.

10. A review of the role and duty statements of the Program's group facilitators. Most GFs are licensed therapists of some sort, and they are functioning as therapists. The program must ensure that GF duty statements require appropriate licensure or certification, and that GFs comply with all laws regulating their practice.

11. Regulations establishing qualifications and criteria for "evaluating physicians" who perform initial multidisciplinary physical and mental examinations on participants as they enter the Program. Since 1981, DMQ has been required to adopt regulations codifying these criteria, but the current regulation (section 1357.3, Title 16 of the California Code of Regulations) is meaningless. This issue was delegated to the Liaison Committee in 2000, but that Committee has never presented alternative standards (*Initial Report* discussion at pages 279–80 and notes 398 and 473).

12. Regulations governing competency examinations for Diversion Program participants. This option was added in SB 1950 (Figueroa) in 2002, and the statute requires rulemaking by the Division of Medical Quality. The Diversion Committee delegated this issue to the Liaison Committee in 2003, which produced draft standards for the conduct of a competency exam allowing Diversion Program participants three chances to pass a basic clinical competency exam in May 2004. The Diversion Committee chair returned those draft standards to the Liaison Committee for more work, but no revised standards have ever been produced (*Initial Report* discussion at note 460).

13. Consideration whether there should be a mandatory "practice cessation" period for participants upon entry into the Diversion Program (as the Board of Registered Nursing requires). In practice, this happens in many cases because the physician immediately enters treatment upon entry into the Program. However, should it be a requirement? At least a presumption? (*Initial Report* Recommendation #62).

14. Whether MBC's Diversion Program is equipped — either now or in the future — to handle singly-diagnosed mentally ill physicians, as required by SB 1950 in 2002 (*Initial Report* discussion on page 253).